OUT-OF-HOME CARE SUPPORT PLAN

Name – Foster Parent 1 (Last, First, MI)	Name – Foster Parent 2 (Last, First, MI)	Provider ID
Name – Licensing Specialist		Date (mm/dd/yyyy)

CURRENT PREFERENCES AND STRENGTHS

Describe any placement preferences and / or considerations indicated by the foster parent(s), including age, gender, race, special needs, contact with birth families, etc.

Describe any strengths observed and / or indicated by the foster parent(s) including skills, education, resources, support network, functional strengths.

AREAS NEEDING SUPPORT AND / OR STRENGTHENING

What concerns / needs required support and / or strengthening?

Describe how each concern / need affects family functioning.

What resources or support systems do the foster parent(s) have available during times of high stress or crisis that will allow them to reduce the stress? What steps are planned for the foster parent(s) to take when they are faced with a high stress or crisis situation?

SERVICES TO SUPPORT FOSTER PARENT(S)

Service	Responsible Party (Agency, Ed. Program, Natural Supports, OHC Consultant, Foster Parent, etc.)	Frequency (One-time, Weekly, etc.)	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
1.				
2.				
3.				
4.				
5.				

OUTCOME MEASUREMENTS

What is the desired outcome of support? Relate measurable outcome to needs or concerns requiring support and / or strengthening.

Describe the indicators and / or measure(s) of successful use of support services to increase skills and abilities.

SIGNATURES

SIGNATURE – Foster Parent	Date Signed
SIGNATURE – Foster Parent	Date Signed
SIGNATURE – Licensing Specialist	Date Signed
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